This medical record is ***confidential*** and will not be released to anyone except as may be required by law.

St. Croix County DHHS-Public Health Dept.
Reproductive Health
1752 Dorset Lane, New Richmond, WI 54017
715-246-8365 Fax 715-246-8298

Date_____

Client #_____

STI/VAGINITIS MEDICAL VISIT

Name _____ Date of Birth _____ Age _____
Last First M

Reason for visit: _____ Phone # to contact you: _____

Please circle if you are allergic to: □ **No Allergies**

□ Penicillin □ Iodine □ Zithromax □ Doxycycline □ Sulfa □ Metal □ Rocephin
□ Tetracycline □ Latex □ Local anesthetic □ Amoxicillin □ Other _____

List medications, vitamins, over the counter drugs, and/or herbs you take:_____

Have you or your partner recently traveled to a region with known Zika or Ebola transmission? Yes No If yes, where:_____

Do you smoke cigarettes? yes no If yes, _____# per day Do you want to quit? yes no

Have you had the Gardasil/HPV vaccine? yes no

MENSTRUAL HISTORY

Day last period began:_____ Was it normal? □ yes □ no

Have you had sex since your period? □ yes □ no If yes, when _____

CONTRACEPTIVE HISTORY

Are you using a method of birth control now? □ yes □ no If yes, what kind? _____

If no, do you want a method? □ yes □ no

Do you use condoms? □ yes □ no □ sometimes

Does your sexual partner(s) agree with your decision to prevent pregnancy and use birth control at this time? yes no

Has anyone ever done anything to your birth control? □ yes □ no (i.e., thrown away your pills, patches, rings, or taken his condom off before or during sex)

SEXUAL HISTORY

Have you had more than one sexual partner in your lifetime? □ yes □ no

Circle if you have: □ vaginal sex □ oral sex □ anal sex □ sex with men sex with women □ sex with both

Circle if your partner(s) have: □ vaginal sex □ oral sex □ anal sex □ sex with men □ sex with women □ sex with both

Have you had a new partner or more than one partner in the **last 90 days?** □ yes □ no □ don't know

Has your partner(s) had a new sex partner or more than one partner in the **last 90 days**? yes □ no □ don't know

Have you ever engaged in a sexual activity where you felt you couldn't say no? □ yes □ no

Have you had symptoms or a diagnosis of an STI in the **last 90 days?** □ yes □ no □ don't know

Has your partner(s) had symptoms or a diagnosis of an STI in the **last 90 days**? yes □ no □ don't know

Have you or your partner(s) used IV drugs? □ yes □ no □ don't know

Have you *ever* had? □ Chlamydia □ Gonorrhea □ HPV/warts □ Herpes □ Syphilis

Have you had Chlamydia in the **last 5 years?** yes no

REVIEW OF SYSTEMS

Gastrointestinal

□ yes □ no Abdominal Pain
□ yes □ no Constipation
□ yes □ no Diarrhea
□ yes □ no Back Pain
□ yes □ no Rectal pain/bleeding/ discharge

Urinary

□ yes □ no Pain/burning with urination
□ yes □ no Frequent urination
□ yes □ no Fever/chills
□ yes □ no Blood in urine
□ yes □ no Have you urinated in the past hour

Vulvo/vaginal

□ yes □ no Sores
□ yes □ no Bumps
□ yes □ no Vaginal itching
□ yes □ no Vulvar itching
□ yes □ no Vaginal odor
□ yes □ no Vulvar soreness
□ yes □ no Discharge, If yes, color:_____
□ yes □ no Pain with intercourse

Respiratory

□ yes □ no Frequent sore throat

Have you or your partner(s) traveled more than 50 miles from the clinic? yes no

Does anything make your symptoms better? yes no If yes, what?_____

Have you recently taken antibiotics? yes no

If yes, when? _____ If yes, for what? _____ If yes, what kind?_____

To the best of my knowledge the above information is complete and correct.

Staff notes:

_____

_____

_____ Time: Face to Face:_____ Counseling _____